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ALEXANDER L. STEVAS,
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No. 80-1594

In the Supreme Court of the United States

OCTOBER TERM, 1980

UNITED STATES OF AMERICA,
PETITIONER,

v.

ERIKA, INC.,
RESPONDENT.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

BRIEF IN OPPOSITION

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Questions Presented

1. Does the Court of Claims have jurisdiction under 28 U.S.C. §1491 to adjudicate a claim that a Medicare intermediary has violated the Constitution or federal statutes in determining benefits payable under Part B of the Medicare Act, 42 U.S.C. §1395j *et seq.*?

2. When Congress enacted 42 U.S.C. §1395ff, did it by implication partially repeal the Tucker Act, 28 U.S.C. §1491, to eliminate Court of Claims jurisdiction over constitutional and statutory challenges to Part B Medicare determinations?

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BRIEF IN OPPOSITION

Respondent Erika, Inc. hereby opposes the petition for a writ of certiorari filed by the Solicitor General on behalf of the United States in this case.

Statutes Involved

28 U.S.C. §1491:

> The Court of Claims shall have jurisdiction to render judgment upon any claim against the United States

> founded either upon the Constitution, or any Act of Congress, or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort .... To provide an entire remedy and to complete the relief afforded by the judgment, the court may, as an incident of and collateral to any such judgment, issue orders directing restoration to office or position, placement in appropriate duty or retirement status, and correction of applicable records, and such orders may be issued to any appropriate official of the United States. In any case within its jurisdiction, the court shall have the power to remand appropriate matters to any administrative or executive body or official with such direction as it may deem proper and just ....

42 U.S.C. §§ 405(h), 1395u and 1395ff are reproduced at Appendix A-1 *et seq.*

Statement of the Case

The only issue before this Court is whether the Court of Claims had jurisdiction to adjudicate the claim of Erika, Inc. ("Erika") that payments due it from the Government under Part B of Medicare were limited or reduced in violation of the Medicare statute and the Constitution.

The Medicare Program is divided into two parts. Part A is a hospital insurance program which covers all qualifying persons. Part B is a voluntary supplemental insurance program. Coverage under both parts extends to any covered person, regardless of age, who requires kidney maintenance dialysis. 42 U.S.C. § 426(e).

Part A, 42 U.S.C. §§1395c to 1395i-2, pays the costs of inpatient hospital services and extended care services. *Id.* §§ 1395c, 1395d.

Part B, 42 U.S.C. §§ 1395j-1395w, generally relates to non-hospital providers such as physicians. *Id.* §§ 1395l, 1395x(s).

Part B benefits are administered by insurance carriers, pursuant to contracts entered into with the Secretary of Health and Human Services.[1] *Id.* §1395u. The carriers determine reasonable charges for services provided to the beneficiaries. 80 per cent of those charges are paid to the beneficiaries or to the providers as assignees of the beneficiaries. *Id.* The statute provides for "a fair hearing by the carrier" if a dispute arises over payment and the amount in controversy is $100 or more. *Id.* § 1395u(b)(3)(C). There is no express provision for review of the carrier's decision as to reasonable charges by the Secretary or any governmental agency.

Erika is a major distributor of kidney dialysis equipment and supplies. As an assignee of its customers/patients, Erika billed its carrier, The Prudential Insurance Company of America ("Prudential"), for sales of covered products to patients eligible for coverage under Part B. Under 42 U.S.C. § 1395u(b)(3), Prudential was to determine the "reasonable charges" for those products and to pay Erika 80 per cent of the "reasonable charges."

Erika's petition sought a money judgment in the Court of Claims to correct Prudential's unlawful and unconstitutional method of setting Erika's "reasonable" charge levels. Erika claimed, and the Court of Claims found on the basis of undisputed facts:

(1) that Prudential, in setting the level of "reasonable charges" for Erika, consistently engaged in a practice directly in violation of the Medicare statute; and

(2) that Prudential had specifically relied on a directive which was acknowledged to be obsolete and which never purported to cover the years in question.[2]

Prudential had thus engaged in practices directly violative of federal law (and its contract with the Government) in its treatment of Erika's Part B claims. Prudential's statutory (and

[1] Or his predecessor, the Secretary of Health, Education and Welfare.

[2] Erika asserted other claims, including constitutional claims, but the above are the only claims as to which the Court of Claims granted relief. The Court of Claims did, however, exercise jurisdiction to resolve those other claims on their merits.

contractual) violation was so substantial and so obvious that it warranted unanimous summary judgment by the full bench of the Court of Claims. In his concurring opinion Judge Nichols was moved to describe Prudential's actions as "virtual spoliation."[3] (P-26a)[4]

In the United States' statement of the case (Petition at 4) the United States defines the jurisdictional issue in manner more reflective of advocacy than accuracy. It asserts that:

> "The issue in this case is whether the Court of Claims has jurisdiction under 28 U.S.C. (& Supp. III) 1491 *to review the amount of benefits* payable under Part B of the ... [Medicare Act] ... for particular medical and other health services." (emphasis added). (Petition at 4)

That statement of the issue to a great extent begs the question.

The jurisdictional question actually decided by the Court of Claims, and hence the issue before this Court, was much narrower than the United States' statement suggests, and in fact the broader issue raised by the United States was determined by the Court of Claims in part in the *government's* favor.

The United States has sought to characterize Erika's claim as nothing more than a dispute over what are "reasonable charges" for particular services. (P-9a). The United States asserted that the legislative history of section 1395ff evidences

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[3] During the pendency of the Government's motion for rehearing, which related to a portion of the Medicare Carriers Manual not directly in issue in the case, Erika's counsel was informed by counsel for the United States that if the motion for rehearing were allowed, Prudential would use that determination to avoid correcting the statutory violation found by the Court of Claims. (App. A-9). Erika brought this to the attention of the Court of Claims (id.), which inserted a final paragraph into its Order on rehearing to prevent Prudential from acting in that fashion. P-32a-33a. The Carrier's attempted action in this regard was consistent with the type of behavior to which Judge Nichols referred.

[4] References to material in the appendix to the Petition are denoted "P-1a", etc. References to the appendix hereto are denoted "A-1", etc.

a clear Congressional intent to bar judicial review of those specific benefit determinations under Part B of Medicare.

The Court of Claims agreed with much of what the United States had asserted. For example, it acknowledged the statutory history of section 1395ff as indicating

> "... that Congress intended to bar judicial review of the amount of a particular benefit determination — as, for example, a carrier's determination that $50 rather than the $100 a physician charged was a reasonable amount for the services." (P.-14a)

That acknowledgement was not dispositive of Erika's claims since the Court viewed this action not as one for review of "thousands" of Part B "reasonable cost" determinations but rather as an action for sums due Erika from the United States as a matter of statutory and contractual right.

The Court of Claims, sitting *en banc*, therefore unanimously held that it had jurisdiction to adjudicate Erika's claims of statutory and constitutional violations in the determination of Part B benefits. Contrary to the United States' statement of the issue, however, the Court in no way sought to exercise jurisdiction to review specific "reasonable charge" determinations. Consistent with that limited view of its jurisdiction and in order not to encroach on areas left to Prudential's discretion and expertise in setting reasonable charge levels, the Court of Claims remanded to Prudential for determination of the amount of damages. (P-17a-18a, 21a).

Argument

I. The Court of Claims' Decision is Consistent with its Statutory Jurisdiction

A. *The Court of Claims has Jurisdiction Over Claims for Medicare Benefits.*

Under the Tucker Act, 28 U.S.C. §1491, the Court of Claims has jurisdiction to render judgment upon any claim

against the United States founded upon the Constitution, federal statute or regulation, express or implied contracts, or in other cases not sounding in tort. The Tucker Act is only jurisdictional, however, and any substantive right to money damages from the United States must be derived from contracts or other statutes. *United States* v. *Testan*, 424 U.S. 392, 398 (1976).

In this case, Erika's substantive right to money damages is both contractual and statutory. Having sold and delivered goods and services to beneficiaries under Part B, and having received assignments of those beneficiaries' claims for payment from Prudential, Erika has a contractual claim for benefits under Part B. *See Fox* v. *Harris*, 488 F.Supp. 488, 495 (D.D.C. 1980). Prudential's obligation to pay Erika in conformity with the statute is contractual as well. *See* 42 U.S.C. §1395u. Even taking Erika's claim as only a contractual one, therefore, the Tucker Act gives the Court of Claims jurisdiction.

Whether Erika has a right to money damages as a statutory claim depends on whether any federal statute "can fairly be interpreted as mandating compensation by the Federal Government for the damage sustained." *United States* v. *Testan*, *supra*, 424 U.S. at 400, quoting *Eastport S.S. Corp.* v. *United States*, 178 Ct. Cl. at 607, 372 F. 2d at 1009. The Medicare legislation, fairly read, mandates appropriate payment to providers. *Whitecliff, Inc.* v. *United States*, 210 Ct. Cl. 53, 536 F.2d 347, 351 (1976), *cert. denied*, 430 U.S. 969 (1977); see P-11a.

Even though a carrier is the contractor/obligor, the United States is the real party in interest in disputes over entitlement to Part B benefits. *Kuenstler* v. *Occidental Life Ins. Co.*, 292 F. Supp. 532, 535 (C.D. Calif. 1968).

The Court of Claims has repeatedly held that 28 U.S.C. §1491 confers jurisdiction upon it to resolve claims for Medicare reimbursement, including claims by providers for reimbursement, unless specific legislation provides that

judicial review is available exclusively elsewhere (or review is clearly precluded in the Court of Claims). *Appalachian Regional Hospitals, Inc.* v. *United States*, 217 Ct. Cl. ____, 576 F.2d 858, 861 (Ct. Cl. 1978); *Whitecliff, Inc.* v. *United States*, 210 Ct. Cl. 53, 536 F.2d 347, 350-51 (Ct. Cl. 1976), *cert. denied*, 430 U.S. 969 (1977). Thus, unless Congress has acted to preclude actions in the Court of Claims relating to Part B benefit determinations, such actions are within the Court of Claims' jurisdiction.

The United States' jurisdictional argument in essence is that Congress has carved out an exception to that general grant of jurisdiction. None of the Congressional actions referred to by the United States, however, deprived the Court of Claims of its jurisdiction under the Tucker Act to decide this case.

B. *Congress did not Preclude Review of Part B Benefit Determinations in the Court of Claims*

The United States' contention that Congress deprived the Court of Claims of jurisdiction in this matter rests on two arguments:

1. That while 42 U.S.C. § 1395ff provides for judicial review of certain Part A benefit determinations and administrative review by the carrier as to the amount of Part B benefits, it is silent as to judicial review of Part B benefit determinations. The United States argues that Congress thereby intended to preclude all judicial review of Part B determinations, citing legislative history suggesting that the decision not to include statutory language permitting judicial review was deliberate.

2. That Section 205(h) of the Social Security Act, 42 U.S.C. § 405(h), through 42 U.S.C. § 1395ii, precludes all judicial review of the carrier's determinations under Part B.

The burden on the United States to establish preclusion is a very heavy one: it must provide "clear and convincing" evidence of congressional intent before this Court will construe a statute to restrict access to judicial review. *Johnson* v.

Robison, 415 U.S. 361, 373-74 (1974). Moreover, the United States is seeking to have a statute which denies judicial review in one forum read by implication to deny judicial review in all other forums. See P-25a-26a.

1) *42 U.S.C.* § 1395ff Does Not Deprive the Court of Claims of Jurisdiction in this Matter.

42 U.S.C. § 1395ff provides, in pertinent part, that an individual dissatisfied with a determination by the Secretary as to:

> (1) whether he or she is eligible under Part A of Medicare,
>
> (2) whether he or she is eligible under Part B of Medicare, or
>
> (3) the amount of benefits under Part A,

is entitled to an administrative hearing by the Secretary and judicial review of the Secretary's final decision. The statute expressly states that no judicial review of the Secretary's determination of the amount of Part A benefits is available if the amount in controversy is less than $1,000.

Because section 1395ff is silent regarding administrative or judicial review of determinations as to the amount of Part B benefits, the United States has argued that it implicitly precludes all judicial review of Part B determinations.

Section 1395ff mandates certain procedures to be followed and decisions to be made by the Secretary. Therefore the simplest and most reasonable explanation for its silence as to judicial review of Part B benefit determinations is that such determinations are to be made by carriers, not by the Secretary. See 42 U.S.C. §1395u; Report of the Senate Committee on Finance, S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 54-55 (1965). It is another section of the statute which requires carriers to have their own review proceeding completely distinct from the administrative hearings provided in section 1395ff. 42 U.S.C. §1395u(b)(3)(C). The carrier is required to:

> establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy .... (*id.*)

The absence of a specific authorization under section 1395ff for administrative and judicial review of decisions regarding the amount of Part B benefits is thus consistent with the fact that there is to be no decision by the Secretary on those issues. A carrier makes those determinations, and hearings by the carrier are provided for in section 1395u, not 1395ff.

Moreover, while Congress in Section 1395ff *expressly* precluded judicial review of certain classes of disputes, it was silent as to judicial review of Part B benefit determinations. Silence on this issue in section 1395ff cannot be taken to be the equivalent of Congress' affirmative preclusion of judicial review of other cases in the same section.

The United States argues, however, that in the legislative history of section 1395ff, the Senate Committe on Finance made the following parenthetical comment to the description of the requirements of hearings by the Secretary contained in section 1395ff:

> ... (Under the supplementary plan, carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits, and the bill does not provide for judicial review of a determination concerning the amount of benefits under Part B where claims will probably be for substantially smaller amounts than under Part A.) ....

Report of the Senate Committee on Finance, S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 54-55 (1965).

This statement is far from an unambiguous withdrawal of jurisdiction. Administrative remedies under Part B were in fact provided in another section of Title 42 (§1395u) and at most the legislative history quoted above indicates that the bill was deliberately silent as to judicial review of Part B determinations of the *amount* of benefits. That conclusion does not mean that Congress intended that all judicial review of Part B determinations was prohibited. In view of the fact that Congress was delegating governmental powers to private parties, it is more reasonable to interpret the statute and its legislative history to mean that judicial review was to be available only to the extent of the courts' existing jurisdiction. Congress merely refused to specify in that section whether carriers' decisions were judicially reviewable. It thereby left the scope of such review to the courts' existing jurisdiction.

The Court of Claims read this legislative history as precluding judicial review of the *amount* of a particular benefit determination, not as precluding all judicial consideration of constitutional and statutory challenges to administrative actions simply because they have an affect on benefit determinations. P-14a. Such a reading was entirely consistent with the Court of Claims' rulings in *Goldstein* v. *United States*, 201 Ct. Cl. 888, *cert. denied*, 414 U.S. 974 (1973), *Appalachian Regional Hospitals, Inc.* v. *United States*, *supra*, 576 F.2d at 861, and *Whitecliff, Inc.* v. *United States*, *supra*, 536 F.2d at 350-51.

The few sentences of legislative history cited by the United States fall far short of the clear and convincing evidence which would warrant its conclusion. In the absence of clear Congressional intent to the contrary, the Court of Claims was not barred from exercising its jurisdiction under 28 U.S.C. §1491. *See Johnson* v. *Robison*, *supra*, 415 U.S. at 373.

2). *42 U.S.C. §405(h) Does Not Preclude Court of Claims Jurisdiction Over Part B Determinations.*

The United States also argues that §205(h) of the Social Security Act, 42 U.S.C. §405(h), precludes all judicial review

of Part B determinations. Its reasoning, however, defies the plain meaning of that section.

Section 405(h) provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of title 28 to recover on any claim arising under this subchapter.

That section is adopted by reference for the Medicare program in §1395ii.

The United States asserts that a decision by a carrier after a hearing conducted by the carrier is included within the statutory language "findings and decisions of the Secretary after a hearing . . . ." Giving the statutory language its plain meaning, however, Prudential is not the Secretary of Health and Human Services, and Section 405(h) simply does not apply.

Moreover, §1395ff distinguishes between determinations to be made by the Secretary and determinations to be made by others, and specifically refers to §405(g) (on judicial review) in relation only to those decisions required to be made by the Secretary. Section 1395u, which sets forth the procedures to be followed by carriers, in no way equates a decision by a carrier with a decision by the Secretary.

When Congress clearly distinguished in §1395ff and §1395u between proceedings to be conducted by the Secretary and proceedings to be conducted by a carrier, it is unlikely that it would blur that distinction in a parallel section by referring to a decision by a carrier as a decision by the Secretary.

Finally, the specific preclusion of actions in the district courts under section 41 of title 28 (28 U.S.C. §1331) to recover

on a claim under Part B of Medicare lends support to the continued exercise of Court of Claims jurisdiction as the appropriate forum for such cases.

II. The Decision Does Not Open the Floodgates of New Litigation or Announce Any Novel Proposition of Law.

The United States has asserted that the decision below would open the floodgates of litigation:

> "... The court's holding threatens to intrude the Court of Claims into the carrier's day-to-day administration of the Medicare program and to open that court to the very flood of small claims Congress sought to foreclose .... Statistics compiled by the Department of Health and Human Services disclose that during calendar year 1980, Part B carriers such as Prudential received 2,163,786 requests for informal review of their initial determinations .... The carriers affirmed their initial determinations in 975,143 of these cases. During the same period, carriers received 26,171 requests for "fair hearings," and their determinations were upheld after a hearing of 7191 cases. If only a fraction of the total number of dissapointed claimants were to seek review in the Court of Claims, the cited statistics indicate that there would be a considerable increase in that court's docket. This would, in turn, strain the scarce resources of the Secretary in defending against relatively minor monetary claims."

This contention is unrealistic. As an initial matter, the expense of litigating in the Court of Claims would screen out all but the most substantial disputes. The Government surely does not seriously contend that the Court of Claims docket is likely to become cluttered with $50 (or even $500) cases. In any event the Court of Claims, which ought to be most familiar with and concerned about the condition of its own docket,

did not share the Government's opinion that the Court might become overburdened or that the resources of the Secretary would be overtaxed by a sudden influx of cases into the Court of Claims.

Furthermore, the Court of Claims decision was not a departure from its prior holdings as to its jurisdiction. The Court of Claims merely followed well-established precedent, including *Goldstein* v. *United States, supra; Appalachian Regional Hospital, Inc.* v. *United States, supra; Whitecliff, Inc.* v. *United States, supra; see Overlook Nursing Home, Inc.* v. *United States*, 556 F.2d 500, 501-502 (Ct. Cl. 1977). The "floodgates" have been open for years, but the resultant "flood" of litigation has not materialized.

Indeed, Court of Claims jurisdiction over Part B issues has been widely recognized by other courts. Even the cases cited by the United States as denying federal District Court jurisdiction over Part B claims often state that the Court of Claims is one forum which does have such jurisdiction. For example, the United States cites *Bussey* v. *Harris*, 611 F.2d 1001 (5th Cir. 1980) to support the proposition that several decisions of Courts of Appeals "make clear that there is no right of judicial review of a carrier's benefit determinations under Part B." (Petition at 20). The Government apparently missed the following in that decision:

> Review is available in the Court of Claims if litigants can state a claim for actual or nominal damages .... This holds true for Part B as well as for Part A actions ....
>
> Appellants could have sought damages in their complaint, although they instead requested declaratory and injunctive relief. Judicial review of any substantial constitutional or statutory claim, therefore, is available in the Court of Claims under 28 U.S.C. § 1491.

611 F.2d 1005 n.6. *Accord, Drennan* v. *Harris*, 606 F.2d 846, 850 (9th Cir. 1979) (also cited by the United States for the same proposition, Petition at 20); *Pushkin* v. *Califano*, 600 F.2d

486, 489-90 (5th Cir. 1979); see *United States* v. *Bellevue Hospital, Inc.*, 479 F.Supp. 780, 734 (D. Mass. 1979); *Fox* v. *Harris*, 488 F.Supp. 488, 495 (D.D.C. 1980). The Court of Claims' view of its jurisdiction in this case has been known to other courts, litigants and potential litigants for years.

The United States' argument that the court of Claims will be interjected into the day to day decisions of the carriers similarly lacks substantial merit. The United States asserted (P-16 n.8) that the court's limitation on its jurisdiction to consider only claims of statutory or constitutional violations was a mere fiction, since in the United States' view any claims of an improper benefit determination could be couched in terms of a statutory violation. Perhaps to reinforce that impression, the United States described the Court of Claims decision as one to review "the amount of benefits payable on the thousands of individual Part B claims assigned to [Erika]." (P-15).

There is no reason to presume that the Court of Claims will not respect a limitation on its jurisdiction which it itself has recognized, or that it is incapable of coping with efforts by litigants to change the substance of their claims by semantic legerdemain.

Moreover, the Court of Claims' actions in this case were consistent with a severely limited view of its jurisdiction, not with the United States' elastic description. The court in fact refused to conduct a review of the "thousands" of individual benefit determinations the United States claims were in issue. It remanded those determinations to Prudential for action consistent with both the statute and the carrier's discretion:

> On the present record, we cannot determine what Erika's customary charges were for its drugs and services for each of the calendar years involved. Nor do we attempt to prescribe the method by which the carrier should make that determination. Prudential might decide to average the different charges made during the calendar year, or to allocate the different charges on the basis

> of the time each was in effect, or to determine the mean charge, or to use some combination of these methods. Perhaps Prudential can devise a better method of calculation.

P-17a.

> The regulations give carriers substantial flexibility in setting reimbursement rates to look at more than just the customary and prevailing charges .... The determination whether to grant particular adjustments and permit departures from prevailing charges during the preceding calendar year, however, is within the discretion of the carrier. We cannot direct Prudential whether or how to exercise that discretion in a particular case.

P-21a.

The Court of Claims has neither opened the floodgates of litigation nor acted in a manner which would encourage attempts to define away the carefully delineated limits on its jurisdiction.

III. The United States' Position Would Unnecessarily Raise Substantial Constitutional Questions

The United States' interpretation would preclude all judicial scrutiny of statutory and constitutional[5] violations by

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[5] The Government seeks to avoid the constitutional issue inherent in its position by pointing out that the majority below found Erika's constitutional claims insubstantial. (The concurring opinion disagreed). However, the Government's jurisdictional arguments apply equally to both constitutional and statutory claims, and the Court of Claims decision applied with equal force to both.

When the Government argued that the decision below encroached on areas which Congress excluded from Court of Claims jurisdiction, the Government expanded on the Court of Claims' own limited expression of its jurisdiction. In contrast, in downplaying the constitutional questions implicit in the decision, the Government narrowed the Court of Claims' language. The issue before this Court is the actual Court of Claims holding, not a version which expands or contracts depending on the point sought to be made.

the carrier. The United States' position in substance is that it can delegate significant governmental functions to an insurance company and yet bar a person injured by the blatantly illegal acts of that company from obtaining any judicial relief. Even if the Medicare statute and the Tucker Act were ambiguous, they should be interpreted so as to avoid such a result.

In *Johnson* v. *Robison*, *supra*, for example, this Court stated that even a statute expressly prohibiting judicial review of a decision of an administrative agency should be construed if at all possible to avoid barring all judicial review of constitutional claims, 415 U.S. at 367. *A fortiori*, when there is no statute expressly prohibiting judicial review, legislative silence in face of a general statute granting jurisdiction to the Court of Claims should be construed to preserve that pre-existing jurisdiction.

The United States in effect asks this Court to decide whether Congress can circumvent the Constitution by delegating to private parties the authority to determine substantive rights and then allowing those parties to exercise that authority in violation of contracts, applicable statutes and even the Constitution without fear of judicial scrutiny. Because a principled alternative to deciding that constitutional question exists, however, that alternative should be chosen. *Johnson* v. *Robison*, *supra*; *see Whitecliff, Inc.* v. *United States*, supra, 536 F.2d at 350-51. The decision of the Court of Claims should be sustained, and certiorari should be denied.

Conclusion

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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APPENDIX

42 U.S.C. §405:

(h) The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under this subchapter.

42 U.S.C. §1395u:

(a) In order to provide for the administration of the benefits under this part with maximum efficiency and convenience for individuals entitled to benefits under this part and for providers of services and other persons furnishing services to such individuals, and with a view to furthering coordination of the administration of the benefits under part A and under this part, the Secretary is authorized to enter into contracts with carriers, including carriers with which agreements under section 1395h of this title are in effect, which will perform some or all of the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations); and, with respect to any of the following functions which involve payments for physicians' services on a reasonable charge basis, the Secretary shall to the extent possible enter into such contracts:

(1)(A) make determinations of the rates and amounts of payments required pursuant to this part to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable);

(B) receive, disburse, and account for funds in making such payments; and

(C) make such audits of the records of providers of services as may be necessary to assure that proper payments are made under this part;

(2)(A) determine compliance with the requirements of section 1395x(k) of this title as to utilization review; and

(B) assist providers of services and other persons who furnish services for which payment may be made under this part in the development of procedures relating to utilization practices, make studies of the effectiveness of such procedures and methods for their improvement, assist in the application of safeguards against unnecessary utilization of services furnished by providers of services and other persons to individuals entitled to benefits under this part, and provide procedures for and assist in arranging, where necessary, the establishment of groups outside hospitals (meeting the requirements of section 1395x(k)(2) of this title) to make reviews of utilization;

(3) serve as a channel of communication of information relating to the administration of this part; and

(4) otherwise assist, in such manner as the contract may provide, in discharging administrative duties necessary to carry out the purposes of this part.

(b)(1) Contracts with carriers under subsection (a) of this section may be entered into without regard to section 5 of Title 41 or any other provision of law requiring competitive bidding.

(2) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1395x(v) of this title);

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policy holders and subscribers of the carrier, and such payment will (except as otherwise provided in section 1395gg(f) of this title) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service and (II) the physician or other person furnishing such service agrees not to charge for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1395y of this title, and if the individual to whom such service was furnished was without fault in incurring the expenses of such service, and if the Secretary's determination that payment (pursuant to such assignment) was incorrect and was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter (except in the case of physicians' services and ambulance service furnished as described in section 1395y(a)(4) of this title, other than for purposes of section 1395gg(f) of this title);

but (in the case of bills submitted, or requests for payment made, after March 1968) only if the bill is submitted, or a written request for payment is made in such other form as may be permitted under regulations, no later than the close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year);

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

(D) will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this part; and

(E) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D) and otherwise to carry out the purposes of this part;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment

is made. In the case of physician services the prevailing charge level determined for purposes of clause (ii) of the preceding sentence for any fiscal year beginning after June 30, 1973, may not exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by economic changes. In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary. The requirements in sub-paragraph (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (i) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health, Education, and Welfare performing functions under this subchapter and acting within the scope of his or its authority, and (ii) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected.

(4) Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsis-

tent with the efficient and effective administration of the insurance program established by this part.

(5) No payment under this part for a service provided to any individual shall (except as provided in section 1395gg of this title) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that payment may be made (A) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (B) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service.

(c) Any contract entered into with a carrier under this section shall provide for advances of funds to the carrier for the making of payments by it under this part, and shall provide for payment of the cost of administration of the carrier, as determined by the Secretary to be necessary and proper for carrying out the functions covered by the contract.

(d) Any contract with a carrier under this section may require such carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(e)(1) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was

based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

(3) No such carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2).

(f) For purposes of this part, the term "carrier" means—

(1) with respect to providers of services and other persons, a voluntary association, corporation, partnership, or other non-governmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization; and

(2) with respect to providers of services only, any agency or organization (not described in paragraph (1)) with which an agreement is in effect under section 1395h of this title.

(g) The Railroad Retirement Board shall, in accordance with such regulations as the Secretary may prescribe, contract with a carrier or carriers to perform the functions set out in this section with respect to individuals entitled to benefits as qualified railroad retirement beneficiaries pursuant to section 426(a) of this title and section 228a-2(b) of Title 45.

42 U.S.C. §1395ff:

(a) The determination of whether an individual is entitled to benefits under part A or part B of this subchapter, and the determination of the amount of benefits under part A of this subchapter, shall be made by the Secretary in accordance with regulations prescribed by him.

(b)(1) Any individual dissatisfied with any determination under subsection (a) of this section as to—

(A) whether he meets the conditions of section 426 or 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title or section 1819, or

(C) the amount of benefits under part A of this subchapter (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1395cc(b)(2) of this title, shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

In the United States Court of Claims

No. 374-77

ERIKA, INC.,
PLAINTIFF
v.
THE UNITED STATES OF AMERICA,
DEFENDANT

MOTION FOR LEAVE TO FILE MEMORANDUM IN OPPOSITION TO MOTION FOR REHEARING

FILED JANUARY 26, 1981
ALLOWANCE ENTERED JANUARY 27, 1981

Plaintiff Erika, Inc. ("Erika") hereby moves to file herewith a Memorandum in Opposition to defendant's Motion for Rehearing. As reason for said motion, Erika states that contrary to the appearance of the motion itself and to the arguments submitted in support thereof, only this week, on January 19, it was informed that the United States in the said motion is seeking in effect a reversal of the decision of the Court of Claims. Erika also learned at this time directly from counsel for the Government that it would use the requested "clarification" against Erika itself to deny Erika the relief to which it is entitled under the Court of Claims' decision.

Prior to January 19, Erika believed that the defendant's motion was no more than a "clarification", with no applicability to the facts of Erika's case. It was not until January 19 that the defendant informed Erika of facts hitherto unknown to Erika—namely, that Prudential has lost, misplaced or disposed of data in the form given it by Erika. Defendant also informed Erika of its position that because of the missing data, it would rely on any grant of the "clarification" requested in the motion for rehearing to justify Prudential acting on remand to insist on the position it took prior to this Court's decision of October 22, 1980, notwithstanding that decision.

The grounds for opposition are more fully set forth in the accompanying memorandum, which plaintiff seeks herein leave to file.

By its Attorneys,

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In the United States Court of Claims

No. 374-77

ERIKA, INC.,
PLAINTIFF
v.
THE UNITED STATES OF AMERICA,
DEFENDANT

MEMORANDUM IN OPPOSITION TO MOTION FOR REHEARING

FILED JANUARY 27, 1981

Plaintiff Erika, Inc. ("Erika") opposes the Motion of defendant United States for rehearing on grounds that contrary to the appearance of the motion itself and to the arguments submitted in support thereof, Erika has just learned that the United States is seeking in the said motion to vitiate the decision of the Court of Claims and to deny Erika the relief to which it is entitled.

In the Motion for Rehearing the United States asserted that all it was seeking was a "clarification"—an order to the effect that the decision in this action did not invalidate a certain portion of the Medicare Carriers Manual. The relevant section of the Manual reads:

> "When a Carrier does not have adequate statistics on charges for suppliers of medical equipment, prosthetics, ambulance services, or for new services, the fees charged and the price lists in effect as of June 30 of that calendar year only should be used. *The intent is to use a price list which can reasonably be assumed not to exceed the median of the prices charged by the supplier for his items and services during the calendar year.* (Emphasis supplied.)

In this action it was Prudential's use of a single price list in setting the "customary charge" rather than actual statistical data as required by law that the Court found was improper. Since Erika did virtually all of its relevant billing to Prudential, and neither Prudential nor the United States had ever claimed that Erika had failed to submit any necessary statistics or other information, it was Erika's belief when the Government's motion was filed that under no circumstances would allowance of the motion effect the outcome of this case. Erika was well aware that Prudential had been supplied with data necessary to make the statutorily required calculations.

In the Government's motion filed on November 5, 1980, this was alluded to on page 4, where it was stated:

> "In the context of the court's assumption that Erika provided Prudential with complete data 'during the calendar year[s]' at issue, the meaning of the court's decision is clear. However, we believe that the Court did not intend to preclude carriers from relying on catalogue price lists when the carrier does not have adequate statistics on charges."

Since the Court's "assumption" was manifestly correct—Erika had provided the necessary data—the clear and intended implication of that language was that the requested "clarification" would not affect the outcome of Erika's case.

In its "substitute" motion filed November 14, 1980, the Government changed the above language to read "In the context of the Court's assumption that Prudential had adequate statistics on Erika's charges..." Still without suspicion of any subterfuge, Erika continued reasonably to assume that the Government was not seeking by the motion for "clarification" to reverse this Court's decision of October 22.

On January 19, 1981 at a meeting with defendant's counsel, representatives of the Social Security Administration and Prudential in an attempt to begin the remand process, counsel for Erika were informed that in the defendant's view if the "clarification" requested in the motion for rehearing were

granted, defendant would interpret it as allowing the conduct by Prudential which the Court condemned in its opinion because Prudential now believed it no longer had the statistical information admittedly submitted by Erika during the relevant years.

Erika therefore must strongly oppose the defendant's efforts to eviscerate the Court's decision.

It is unquestioned that Erika originally provided Prudential with sufficient information for Prudential to develop the statistics necessary to satisfy its obligations as stated in the Court's decision.

Prudential and the Government, however, now claim that due to the passage of time while this case was pending Prudential no longer has the necessary statistics, or that recreation of them would be prohibitively difficult and expensive. Prudential now asserts that under the quoted language of section 5010.1 of the Medicare Carriers Manual it should be allowed on remand to use the single date catalogue approach which it was sued for using in the first place. It seeks, therefore, to evade completely the decision of this Court since such an action would result in Erika receiving no relief whatsoever for the improper actions of Prudential.

Such an attempt is outrageous and should not be countenanced.

Any loss of data by Prudential during the time when Erika was pursuing its mandated administrative and judicial remedies was entirely due to Prudential, not to any action or fault on Erika's part. Prudential, however, now seeks to absolve itself of its own failure lawfully to use the data supplied it by Erika by invoking on its own negligence to preserve that data during the pendency of this action. Erika must not be penalized by Prudential's loss, destruction or alternation of its records.

The motion for rehearing is not seeking a "clarification", it is seeking a reversal. Erika therefore opposes it, and asks that the Court's decision and order for remand be left intact, and that excuses for defendant's asserted inability to comply with the Court's order not be sanctioned in advance.

Respectfully submitted,

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